COLORADO DEPARTMENT OF LABOR AND EMPLOYMENT
DIVISION OF WORKERS' COMPENSATION

Supplemental Report of Return to Work

Workers' Compensation (WC) #: _____ Date of Injury: _____

Employee Name:_____ Carrier Claim #: _____

Social Security #: _____ *[###]* - *[##]* - *[####]* Employer: _____

The purpose of this form is to provide information to determine the accurate payment of temporary disability benefits.

Instructions:

1. **This form may be completed by the employee or employer.**
2. **This form should be completed each time the employee returns to work at full or reduced wages and/or hours.**
3. **This form should be forwarded to your workers' compensation carrier.**

1. Last day employee worked: _____
2. Date employee returned to work: _____
3. Employee's return-to-work-wages (Check the box that applies):

☐ Full wages/full hours

☐ Reduced wages and/or hours

(Please provide wage information to the claims adjuster every two weeks during periods of wage loss)

Additional information:

_____

_____

_____

_____

Completed by (Check the box that applies): ☐ Employee ☐ Employer

_____ _____

Name Date
(Cannot be dated prior to the return to work date)

Address: _____

Phone #: _____ Email: _____